

DATE: _____ NEEDS BY DATE: _____
SHIP TO: PATIENT OFFICE OTHER _____

Patient Information

Patient Name	
Address	
City, State, Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female

Clinical Information

Diagnosis Code: K50.90 Crohn's Disease K51.90 Ulcerative Colitis
 Other: _____

Drug Allergies: _____

History: Has the patient been treated previously for this condition? Yes No

- | | |
|--|----------------|
| <input type="radio"/> NSAIDS | Duration _____ |
| <input type="radio"/> MTX | Duration _____ |
| <input type="radio"/> Biologics | Duration _____ |
| <input type="radio"/> Sulfasalazine | Duration _____ |
| <input type="radio"/> 5-ASA (5-Aminosalicylates) | Duration _____ |
| <input type="radio"/> Azathioprine | Duration _____ |
| <input type="radio"/> Corticosteroid | Duration _____ |
| <input type="radio"/> 6-MP (6-Mercaptopurine) | Duration _____ |
| <input type="radio"/> Other | Duration _____ |

• Is the patient currently on any therapy? Yes No

• List Meds: _____

• Will patient stop taking meds before starting the new med? Yes No

• How long will the patient wait before starting the new med? _____

• Other meds patient is on? _____

• Has patient received PPD (skin test)? Yes No

• Results: _____

Provider Information

Prescriber Name		
DEA #	NPI #	License #
Address		
City, State, Zip		
Phone	Fax	
Contact Person		

Product	Quantity	Prescription Information	Supply	Refills
<input type="radio"/> Cimzia®	<input type="radio"/> 200x2 Prefilled Syringe <input type="radio"/> 200x2 LYO Powder	<input type="radio"/> Starter Kit: Inject 400mg subcutaneously at Weeks 0,2 and 4 <input type="radio"/> Inject 400mg subcutaneously once every 4 weeks	1 Kit 4 week supply	none _____
<input type="radio"/> Creon®	<input type="radio"/> 3,000 <input type="radio"/> 6,000 <input type="radio"/> 12,000 <input type="radio"/> 24,000 <input type="radio"/> 36,000	Take ___ capsules three times daily with meals and ___ capsules with ___ snacks daily for a total of _____ capsules a day	_____	_____
<input type="radio"/> Dificid®	200mg Tablet	1 tablet by mouth twice a day with or without food for 10 days.	20	_____
<input type="radio"/> Entyvio®	300mg Vial	<input type="radio"/> Loading Dose: Infuse 300mg IV over 30 minutes at Week 0, Week 2 and Week 6 <input type="radio"/> Maintenance: Infuse 300mg IV over 30 minutes every 8 weeks	3	none _____
<input type="radio"/> Humira®	<input type="radio"/> Crohn's/UC Starter Package (6mg - 40mg Pens) <input type="radio"/> 40mg Pen <input type="radio"/> 40mg PFS	Inject 160mg given as <input type="radio"/> Four 40mg SubQ Day 1 OR <input type="radio"/> Two 40mg SubQ Days 1 & 2 then Week 2 inject 80mg (Two 40mg injections) subcutaneously on Day 15 <input type="radio"/> Week 4+: Inject 40mg subcutaneously every other week	Loading Dose 4 week supply	none _____
<input type="radio"/> Humira® Citrate Free	<input type="radio"/> Crohn's/UC Starter Package (3mg - 80mg Pens) <input type="radio"/> 40mg Pen <input type="radio"/> 40mg PFS	Inject 160mg given as <input type="radio"/> Two 80mg SubQ Day 1 OR <input type="radio"/> One 80mg SubQ Days 1 & 2 then Week 2 inject 80mg subcutaneously on Day 15 <input type="radio"/> Week 4+: Inject 40mg subcutaneously every other week	Loading Dose 4 week supply	none _____
<input type="radio"/> Remicade® Wt: _____	100mg/kg Vial	Loading Dose: <input type="radio"/> Infuse _____mg/kg IV on Week 0, Week 2, Week 6, then Maintenance: <input type="radio"/> Infuse _____mg/kg IV every _____ weeks for _____ infusions	Loading Dose 4 week supply	none _____
<input type="radio"/> Simponi®UC	<input type="radio"/> 100mg SmarJect <input type="radio"/> 100mg Prefilled Syringe	<input type="radio"/> Inject 200mg subcutaneously at week 0, then 100mg at week 2, 100mg every 4 weeks, <input type="radio"/> Inject 100mg subcutaneously once every 4 weeks	Loading Dose 4 week supply	none _____
<input type="radio"/> Epipen®	0.3mg	Inject 1 pen intramuscularly once, may repeat if necessary. Call 911 if needed.	2	_____
<input type="radio"/> Stelara®	90mg Prefilled Syringe	Inject 90mg subcutaneously every 8 weeks Infusion Dose Date: _____	8 week supply	_____
<input type="radio"/> Xeljanz®	<input type="radio"/> 10mg <input type="radio"/> 5mg	1 tablet by mouth twice a day	60	_____
<input type="radio"/> Other	_____	_____	_____	_____

PLEASE FAX COPY OF : 1) PRESCRIPTION CARD FRONT & BACK 2) CLINICAL NOTES 3) MEDICAL CARD FRONT & BACK

By signing this form and utilizing our services, you are authorizing Eventus Rx, Inc to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps) Substitution Permitted Date Prescriber's Signature (no stamps) Dispense As Written Date

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